This is a fill-in form made up of text fields and check boxes. Select a field by clicking it with a mouse. Move between fields by pressing the tab key or shift-tab combination.

NOTICE OF ASSESSMENT REPORT
Washington State Health Insurance Pool
(Ref. Regulatory Code of Washington Chapter 48.41)

Under Chapter 48.41 RCW, all members of the Washington State Health Insurance Pool (WSHIP), are subject to the assessment for WSHIP expenses.

Instructions:
This Report should be filed with the Office of Insurance Commissioner at the address below. Please complete and return it by February 28, 2003.

- **MEMBER INFORMATION**

COMPANY NAME **Please enter the full legal name** NAIC #

COMPANY ADDRESS Street Address or P. O. Box

City, State ZIP Code

CONTACT NAME CONTACT PHONE #

BILLING ADDRESS (IF DIFFERENT)

BILLING CONTACT BILLING CONTACT PHONE #

1. 2002 ENROLLMENT AFFIDAVIT – FOR HEALTH PLANS

Please report Washington resident insured persons under your organization's health plans, including spouse and dependents **as of the last day of each month in 2002**. This total should include only those persons covered under "health plans" as defined in RCW 48.41.030(11).

Please check this box if this does not apply to your organization: ☐

JAN	FEB	MAR	APR	MAY	JUN

JUL	AUG	SEPT	OCT	NOV	DEC	Total
						0

2. 2002 ENROLLMENT AFFIDAVIT – FOR STOP LOSS COVERAGE (SELF-INSURED ENROLLMENT)

Please report Washington resident insured persons, including spouses and dependents, who have coverage through a self-insured plan that has been reinsured by your organization's stop loss plan **as of the last day of each month in 2002**.

Please check this box if this does not apply to your organization: ☐

JAN	FEB	MAR	APR	MAY	JUN

JUL	AUG	SEPT	OCT	NOV	DEC	Total
						0

NOTICE OF ASSESSMENT REPORT
Washington State Health Insurance Pool
(Ref. Regulatory Code of Washington Chapter 48.41)

3. 2000 ENROLLMENT AFFIDAVIT – FOR STOP LOSS COVERAGE (SELF-INSURED ENROLLMENT)

Please report Washington resident insured persons, including spouses and dependents, who have coverage through a self-insured plan that has been reinsured by your organization's stop loss plan **as of December 31, 2000**.

Please check this box if this does not apply to your organization: ☐

TOTAL STOP LOSS RESIDENT INSURED PERSONS:

- **DECLARATION OF ACCURACY**

I hereby declare under penalty of perjury that the enrollment information provided pursuant to this report is true and correct to the best of my knowledge and belief. I am authorized to execute this declaration on behalf of **Please enter the full legal name** and certify that **Please enter the full legal name** understands that this information will be used to calculate the assessment due and owing the Washington State Health Insurance Pool as further explained in RCW 48.41.090.

Signature of Officer _____ Date

Printed Name of Officer Phone Number

Title of Officer

- **PREPARATION QUESTIONS**

Client Accounting Telephone: (317) 614-2018

- **MAILING ADDRESS FOR OFFICE OF INSURANCE COMMISSIONER**

Office of Insurance Commissioner
Attn: Company Supervision
PO Box 40259
Olympia, WA 98504-0259

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